



Cultural Competence: A Strategic Plan

Delaware Department of Health and Social Services
Division of Substance Abuse and Mental Health
(DSAMH)



**Delaware Department of Health and Social Services
Division of Substance Abuse and Mental Health
(DSAMH)**

www.state.de.us/dhss/dsamh/dmhome.htm

Cultural Competence: A Strategic Plan

May 2004

Prepared by:

DSAMH Cultural Competence Committee

Renata Henry, Division Director

Carol L. Kuprevich, Ed.D., Chair

Frann Anderson, LCSW, CADC,
Licensing

Tita Gontang, MSW, CADC,
Kent/Sussex Detoxification Center

Elizabeth Bolton, Ph.D.,
Community Mental Health

Donald Samuels, MSW,
Provider Representative

Patricia Brooks,
Substance Abuse Unit

Gwendolyn Scott-Jones, MSW,
Crisis Intervention

Catalina Figueroa,
La Red Health Center

Chris Stoudemire, M. Ed.,
Delaware Psychiatric Center

Patricia Ford, MA, CADC,
Delaware Psychiatric Center

**In Collaboration with:
DSAMH Executive Staff**

Renata Henry, Director

Susan Gumbs, Deputy Director

Stephen Dettwyler, Ph.D.

Paul E. Poplawski, Ph.D.

Harris Taylor

Michael Kelleher

Ranga Ram, M.D.

Maurice Tippet

Jack Kemp

Michael Talmo



Effective Date: January 2, 2003

**Division Director's Statement:
Division of Substance Abuse and Mental Health Cultural Competence
Committee**

I have established the Division of Substance Abuse and Mental Health (DSAMH) Cultural Competence Committee (CCC) as an advisory group to the DSAMH Executive Staff. The Committee's mission is to create a process of developing a culturally competent Division and system of service delivery and to serve as a change agent in that evolutionary process.

In order to foster a healthy and responsive environment, it is essential to include individuals from a variety of cultural backgrounds and from a variety of units of the Division in the decision making process. One way to achieve this is by ensuring participation by representative groups of our workforce and of our community.

DSAMH is committed to the principles and spirit of this statement.

A handwritten signature in black ink that reads "Renata Henry". The signature is fluid and cursive, with the first name "Renata" being larger and more prominent than the last name "Henry".

Renata Henry, Division Director

PREFACE

The Division of Substance Abuse and Mental Health firmly believes that it must recognize and thoroughly understand the role that culture and ethnicity play in the lives of the people they serve. This strategic plan is written to serve as a guide in the ongoing developmental and evolutionary process toward a multicultural competent service delivery system. This plan's creation stems from DSAMH's commitment to improve the quality of the delivery of mental health and substance abuse services. The goals and objectives of the plan are designed to create a system of care that takes cultural factors into account when working with every individual.

The strategic plan began with the recognition that participation from the Division, the provider, the consumer, and the community was critical to the developmental process. Whereas DSAMH makes decisions that have long-range consequences for the population it serves, it is also responsible for ensuring that cultural awareness and eventually, competence, is integrated into those decisions and into the system of care. DSAMH has established a solid foundation on the road toward cultural competence as an organization. Key to the change process is the firm commitment of the DSAMH leadership. Renata Henry, Division Director, her executive staff and other management staff have demonstrated this by their provision of resources and ongoing support of the Cultural Competence Committee (CCC). Their leadership, continued involvement, understanding of and commitment to true multicultural organization development is integral for the change process to be successful.



Carol L. Kuprevich, Ed.D.
Chair, Cultural Competence Committee

Table of Contents

Title Page	Page Number
DIVISION DIRECTOR'S STATEMENT	3
PREFACE	4
INTRODUCTION	6
DSAMH BELIEFS AND VALUES	8
BACKGROUND	9
RATIONALE FOR A CULTURAL COMPETENCE PLAN	10
DSAMH CULTURAL COMPETENCE STRATEGIC PLAN	11
GOAL 1	12
GOAL 2	15
GOAL 3	16
GOAL 4	17
GLOSSARY	18

INTRODUCTION

This document is the strategic plan developed by the Cultural Competence Committee for the Division of Substance Abuse and Mental Health (DSAMH). DSAMH is committed to establishing multicultural principles and practices throughout its system of services and programs as it works toward the critical goal of developing a culturally competent service system. This commitment supports the DSAMH Mission Statement: To improve the quality of life for adults having mental illness, alcoholism, drug addiction, or gambling addiction by promoting their health and well being, fostering their self-sufficiency and protecting those who are at risk. The Cultural Competence Committee work supports the DSAMH mission by facilitating the creation of a process by which DSAMH can describe and respond to the needs and differences of all individuals, regardless of their race, gender, religion, physical or mental status, age, sexual orientation, and ethnic or cultural background. (Note: whenever culture and/or ethnicity are mentioned it is a reference to this entire list.)

The content of this document was developed after careful consideration of the Surgeon General's supplemental information to the Mental Health Report. As David Satcher, M.D., Ph.D. described in the preface to *Mental Health: Culture, Race, and Ethnicity*, "...all Americans do not share equally in the hope for recovery from mental illnesses. This is especially true of members of racial and ethnic minority groups. [It is important to] place emphasis on the role that cultural factors play in [behavioral healthcare]. The cultures from which people hail affect all aspects of mental health and illness, including the types of stresses they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess. Likewise, the cultures of clinicians and service systems influence the nature of mental health services."

Cultural competence can be defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. A culturally competent system acknowledges and incorporates the following at all levels: Valuing diversity; Cultural self-assessment; Vigilance toward the dynamics that result from cultural differences; Expansion of cultural knowledge; and, Adaptation of services to meet culturally-unique needs. (Cross, et.al., 1989)

This plan will provide direction to DSAMH over the next three years. It establishes goals, objectives, and activities to serve as a guide for policy and budget development, resource allocation, and data collection. It also begins to address recruitment and retention issues and culturally competent services within DSAMH and throughout the provider agencies. The focus of the plan is a vision for the future as it relates to multiculturalism. Action plans will be developed from this document on an annual basis and will include goals and objectives with the express purpose of providing

leadership and effective continuity for organizational development relative to the development of a culturally competent system of care. Toward this end the Cultural Competence Committee will be an active and guiding body and ongoing participation by its members will provide leadership and effective continuity.

DSAMH understands the statement in the National Association of State Mental Health Program Directors' (NASMHPD) work entitled ***Cultural Competency: Strategies for Moving Knowledge into Practice in State Mental Health Systems*** that suggests the magnitude of this undertaking. "Implementing cultural competence is a complex, 'non-linear,' multi-level process involving not only interactions at different levels within the system but also interactions with the community and other social service agencies as well." This three-year plan has been drafted with this statement in mind. Each of the activities in the plan includes identified collaborators to begin the process. The intent of the language of the plan is that it is inclusive and subject to additions as the implementation of particular aspects of the plan is undertaken. The plan will be reviewed at least annually and collaboration is expected to become a larger aspect of the work as it evolves.

The NASMHPD model for action as described in the document ***Cultural Competency: Strategies for Moving Knowledge into Practice in State Mental Health Systems***, includes: leadership, commitment by key staff and stakeholders, structural changes, resources, culturally responsive services and the recommendations for action that have been reviewed by the committee members and incorporated into this plan. As emphasized in the NASMHD model, the "commissioner must lead the process and garner the commitment of key staff and stakeholders...Commissioners should provide a signal to the entire system that cultural competence is a high priority for them...Commissioners should develop mechanisms to ensure commitment by key staff and stakeholders, especially in all future programming." The Director of the Division of Substance Abuse and Mental Health has spearheaded this cultural competence initiative from its inception and continues to play a key leadership role by reiterating the message of the importance of cultural competence in public, to staff, stakeholders, and to her executive team. This serves as an exemplary process for others to follow.

One of the major recommendations of the NASMHPD report was that each state mental health system should assess conditions related to cultural competence ...as a starting point before any implementation plan is set in motion. Thus, one major goal in the first year is to initiate a self-assessment of DSAMH to establish baseline data and identify the multicultural strengths and needs. The self-assessment will also be a way to obtain a broader range of perceptions and opinions, from a multicultural perspective, about the places where DSAMH employees work. DSAMH is dedicated to building a workforce that reflects the population it serves. A diverse workforce provides a variety of talents, skills and viewpoints, and fosters solutions to problems.

DSAMH BELIEFS AND VALUES

DSAMH has described its *way of doing business*, relative to cultural competence, through the formation of cultural competence beliefs and values as follows.

- DSAMH acknowledges that a person's culture is relevant to their recovery and the services they receive.
- DSAMH believes that culturally sensitive practices can help reduce barriers to effective care.
- DSAMH believes that cultural competence facilitates individualized care to the consumer.
- DSAMH respects individual differences and recognizes cultural variability as a critical component of cultural competence.
- DSAMH understands that consumer and family satisfaction with service provision is an important indicator of cultural competence.

These beliefs and values as a *way of doing business* are promoted through inclusion in agency strategic plans, goals, and objectives; integration into training and in-service curricula; in contract performance measures and request for proposal (RFP) language; in collaborative efforts with stakeholders, recipients, families, advocates and policy makers, with equitable distribution of resources, and through the promotion of service access to all populations with specific attention given to traditionally underserved populations.

BACKGROUND

While Cultural Competence has been initiated in many ways throughout DSAMH, there has never been an organized, system wide approach to developing a culturally competent system of care. For example, in calendar year 2000 DSAMH offered an entire 5-day Summer Institute consisting of 33 workshops on the theme ***Responding to the Needs of Diverse Populations***. It was attended by over 500 persons from the DSAMH system of care and received excellent reviews but there was not an organized approach in place to help the workforce identify which workshop topics would enhance individual growth or to reinforce the education to sustain long-term impact on the system. Likewise, in the DSAMH annual training catalog, workshops are consistently offered relative to further development toward cultural competence of individual service providers with limited or no follow-up and limited direction for individuals to determine what workshop topics would be most beneficial to their personal growth.

In 1999 the Behavioral Health Services for Deaf and Hard of Hearing Action Committee was established by DSAMH through the Office of Consumer Relations to address the needs of the deaf, hard of hearing, late deafened, and deafblind community within the behavioral healthcare arena. While the efforts of this committee have been substantial, systemic growth and a larger arena of application could be of benefit to this special population. Similarly, study circles were initiated at the Delaware Psychiatric Center to help employees address issues related to cultural differences. This nationally recognized program, if implemented system wide, could have a greater impact on the larger environment that is DSAMH.

RATIONALE FOR A CULTURAL COMPETENCE PLAN

DSAMH faces a series of issues for which cultural competence may be at least part of the solution:

- The insufficient analysis of data related to cultural and ethnic variables upon which to base decisions regarding multiculturalism
- The lack of ethnic and cultural data on the incidence of issues, the need for services, and the effectiveness of services among the various identified groups
- The existence of many cultural competence education programs that have not been integrated into a state-wide program of multicultural organizational development
- The existence of stand-alone committees and other work related to multiculturalism whose efforts have not been integrated state-wide
- The unknown level of cultural competence within DSAMH

Cultural competence research and experience indicate that cultural issues influence dropout rates, recidivism, cost effectiveness, access, and quality of care. Substance abuse and mental health services that are based on assumptions of monoculturalism and universality tend to create a deficit in the delivery of culturally competent services in the mental health and addictions systems of care.

This deficit is of particular concern relative to the rapidly changing composition of the US population, notably the expanding underserved cultural populations. Based on present population and projected growth rates, the US Bureau of the Census (1996) predicts that the United States will undergo population changes that will have minority groups representing close to 50% of the population by the year 2020, less than 16 years from now. Shifts in ethnic population are not just about numbers, but also about the impact of cultural diversity. Our mental health and substance abuse systems need to develop new approaches to address the cultural mix among consumers.

These same population changes are expected to occur in our system as well. According to the 2000 Census, there were 783,600 people in Delaware. A total of 5,135 clients received mental health services via the public sector in fiscal year 2002. The ethnic breakdown of the clients served was 72.1% Caucasian, 24.1% Black, 0.6% Native American, 0.7% Asian/Pacific Islander, 3.4% Hispanic, and 1.2% Other. Almost fifty-one per cent of clients receiving mental health services were women, and the largest age group was aged 35-44 years (28 %).

In substance abuse services, 9,977 clients were served in fiscal year 2002. The percent of clients of different ethnic groups were: 61.8% Caucasian, 34.9% Black, 4.9% Hispanic, 0.9%

Asian/Pacific Islander, 0.7% Native American and 1.4% Other. Males treated in the DSAMH system of care represented approximately 76.6 % as compared to 23.3% females. The largest age group was 35-44 (29.6 %).

Issues of mental illness and substance abuse intersect with the health, safety and quality of life for individuals and the effect is often devastating. The cost is high, the harm and suffering is widespread and, based on the numbers described, the number of those affected is steadily rising. There are also populations in our State for whom we believe we have very incomplete data.

DSAMH CULTURAL COMPETENCE STRATEGIC PLAN

As a result of the initial meetings of the CCC, four well-defined goals, with collaborative objectives and activities were produced and accepted by the DSAMH Executive Staff. These goals are components of an overall plan to effect system change and will need to be reviewed and modified with regularity in order to be responsive as the needs of the system change.

“Building capacity for research, training, and community leadership is essential to meet the needs of racial and ethnic minorities in the 21st century. The demographic changes anticipated over the next decades magnify the importance of eliminating differences in access to services. Where gaps exist in the evidence base about the prevalence, perception, course, detection, and treatment of mental illness [and other behavioral health issues] in racial and ethnic minority populations, individuals must be trained and supported to carry out programs...Where shortages of accessible services are evident, both mainstream and bilingual-bicultural providers and administrators must learn to create culturally appropriate and evidence-based systems of care. It is necessary to expand and improve programs to deliver culturally, linguistically, and geographically accessible services. Where leadership is lacking... encouraging grassroots efforts will help to strengthen the voices of racial and ethnic minorities.”

Just as the Surgeon General's report noted these needs in the culminating statements of *Mental Health: Culture, Race, and Ethnicity* the described needs are applicable to DSAMH's three-year cultural competence plan. Working toward cultural competence in our DSAMH system is the right thing to do for all Delawareans. This plan sets forth a foundation and is the beginning of an ongoing process.

DSAMH CULTURAL COMPETENCE STRATEGIC PLAN

Goal **1**

Develop policies, structures, and environments that promote cultural competence.

OBJECTIVE 1.1

The Cultural Competence Committee (CCC) will function as the multi-cultural organizational change agent.

Activities

In collaboration with the DSAMH executive committee:

- Review criteria for membership on CCC
- Identify roles and responsibilities of CCC members
- Review cultural competence plans and initiatives developed by other states and localities
- Recommend to the Director protocols that describe the relationship of the CCC to the DSAMH executive committee
- Conduct an ongoing individual and organizational self-assessment for planning, implementing, and evaluating services
- Review agency policies and mission statements to reflect a culturally competent service delivery system
- Conduct annual evaluation of multi-culture initiatives

OBJECTIVE 1.2

Promote cultural competence in management and supervision issues within DSAMH and throughout the service system.

Activities

In collaboration with the DSAMH executive committee, initiate proposals to:

- Develop cross-cultural supervision skills
- Create a welcoming multicultural environment to include the physical atmosphere, e.g., pictures, magazines displayed in waiting areas, written materials in diverse languages, and other inclusive measures
- Provide technical assistance in areas of cultural competence to all levels of management in DSAMH and throughout the system of care

OBJECTIVE 1.3

Promote the role of DSAMH as a truly equal opportunity employer.

Activities

In collaboration with the Human Resources Division of DHSS and DSAMH:

- Recruit employees who can address the needs of a multicultural/multilingual population
- Ensure that cultural competence is included in performance evaluations
- Review DHSS Equal Opportunity Employer Plan to determine level of DSAMH compliance
- Review the existing standards for state employees of the Governor's EEO Council
- Create a sub-committee of the CCC to review existing standards to determine if applicable to DSAMH's plan
- Make recommendations for adoption to the CCC

OBJECTIVE 1.4

Develop a system of care that demonstrates an understanding of cultural competence and cultural diversity when rendering services to consumers, their families, and networks.

Activities

In collaboration with DSAMH and provider agencies:

- Introduce cultural competence guiding principles to providers
- Explore program models that are working in Delaware and other states to identify elements that are effective
- Fund cultural competency demonstration projects within budget constraints
- Collect feedback from consumers, families and the multicultural forum
- Adapt and implement client assessment and diagnostic instruments that are culturally sensitive
- Conduct client surveys and develop other client satisfaction measurement processes
- Incorporate into provider contracts specific language aimed at achieving and improving cultural competency

OBJECTIVE 1.5

Incorporate cultural competency into DSAMH business practices.

Activities

In collaboration with Community Service Providers and DSAMH's Training, Fiscal, and Management Information Services Departments:

- Contract and collaborate with community-based agencies that have historically been successful in serving ethnic, cultural, and specialty populations
- Adopt clinical protocols that will consider the impact of culture, language, race, and ethnicity in the delivery of mental health and addiction services

Goal **2**

Develop cultural competence standards, benchmarks, outcome methods, and mechanisms for data collection.

OBJECTIVE 2.1

Develop cultural competence standards.

Activities

In collaboration with the Executive Staff, Management Information Systems, DSAMH staff, clients, and providers:

- Survey other states, provider agencies and the federal government for samples of standards and measures
- Create a committee to draft DSAMH cultural competence standards
- Create a task force with DSAMH staff, clients, and providers to review, modify, and finalize standards
- Review the existing standards for state employees of the Governor's Equal Employment Opportunity Council
- Create a sub-committee of the CCC to review existing standards to determine if applicable to DSAMH's plan
- Make recommendations for adoption to the CCC

OBJECTIVE 2.2

Develop performance measures based on the adopted standards

Activity

- Conduct client surveys and develop other client satisfaction processes

OBJECTIVE 2.3

Develop data elements and collection mechanisms that support the performance/outcome measures

Activities

- Develop mechanisms that identify and assess the mental health and addiction needs of the State's population including ethnicity and language preference
- Develop mechanisms that evaluate the extent to which treatment is culturally and linguistically appropriate to clients being served

OBJECTIVE 2.4

Analyze and aggregate data and utilize findings to develop improvement strategies

Activities

- Enhance strengths and address needs identified as a result of the individual and organizational assessments
- Disseminate information

Goal **3**

The implementation of a training program for employees that will enable them to meet the standards of cultural competence as established by the Division.

OBJECTIVE 3.1

Develop a comprehensive training curriculum for cultural competency.

Activity

In collaboration with DSAMH Office of Training and Education:

- Address training needs identified from the results of the assessments.

Goal 4

Strengthen internal and external communications among under-represented communities and institutions

(e.g., deaf, hard of hearing, late deafness, deafblind, faith based, gay, lesbian, bisexual, trans-gendered).

OBJECTIVE 4.1

Enhance communication at all levels of operation.

Activities

In collaboration with executive committee, other DSAMH management, community service providers, and, when indicated, DHSS Public Information Officer.

- Develop mechanisms (e.g., newsletter, festivals, videos, etc.) to assure that there is a mutual flow of information on multicultural issues and activities among division and employees, CCC and all staff, etc.
- Utilize existing division communication mechanisms
- Explore the possibility of developing a multicultural resource center

GLOSSARY OF TERMS

ACCESS: Accessibility of services in a manner that facilitates their use by people who need them; providing the opportunity for people to obtain mental health services from behavioral health providers; providing an active program of community information and outreach to motivate participation in services. (1997, Cultural Competence Standards, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, p. 57.)

CULTURE: The word “culture” [as used in cultural competence] implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. (Towards a Culturally Competent System of Care, Volume 1, March, 1989, National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center, p. 13.) Culture is broadly defined as a common heritage or set of beliefs, norms, and values. It refers to the shared, and largely learned, attributes of a group of people. Anthropologists often describe culture as a system of shared meanings. People who are placed, either by census categories or through self-identification, into the same racial or ethnic group are often assumed to share the same culture. Yet this assumption is an over generalization because not all members grouped together in a given category will share the same culture... A key aspect of any culture is that it is dynamic: Culture continually changes and is influenced both by people’s beliefs and demands of their environment. (2001, U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity; A Supplement to Mental Health: A Report of the Surgeon General, p. 9.)

COMPETENCE: The word “competence” [as used in cultural competence] implies having the capacity to function effectively. (March, 1989, Towards a Culturally Competent System of Care, Volume 1, National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center, p. 13.)

CULTURAL COMPETENCE: Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. Culturally competent agencies work to hire unbiased employees, seek advice and consultation from the minority community, and actively decide what they are and are not capable of providing to minority clients. (March, 1989, Towards a Culturally Competent System of Care, Volume 1, National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center, p. 17.)

DIVERSITY: Valuing diversity is an essential element toward culturally competent institutions. In this regard to value diversity is to see and respect its worth. A system of care is strengthened when it accepts that the people it serves are from very different backgrounds and will make different choices based on culture. While all people share common basic needs, there are vast differences in how people of various cultures go about meeting those needs. These differences are as important as the similarities. Awareness and acceptance of differences in communication, life view, and definition of health and family are critical to the successful delivery of services. (March, 1989, Towards a Culturally Competent

System of Care, Volume 1, National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, p. 19.)

ETHNICITY: A precise definition of ethnicity is elusive. (2001, U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity; A Supplement to Mental Health: A Report of the Surgeon General, p. 7.) Ethnicity refers to a common heritage shared by a particular group. Heritage includes similar history, language, rituals, and preferences for music and foods. Historical experiences are... pivotal to understanding ethnic identity and current health status... (p. 9)

POLICY: A plan or course of action designed to influence and determine decisions, actions, and other matters; a course of action, guiding principle or procedure considered to be expedient, prudent, or advantageous.

RACE: Despite the popular view, there are no biological criteria for dividing races into distinct categories (Lewontin, 1972; Owens & King, 1999). The visible physical traits associated with race are defined by a tiny fraction of our genes and do not reliably differentiate between the social categories of race. The strongest, most compelling evidence to refute race as a biological category comes from genetic analysis of different racial groups. There is overwhelmingly greater genetic variation within a racial group than across racial groups (Barbujani et al., 1997). Race is not a biological category, but it does have meaning as a social category. Different cultures classify people into racial groups according to a set of characteristics that are socially significant. The concept of race is especially potent when certain social groups are separated, treated as inferior or superior, and given differential access to power and

other valued resources. This is the definition used in this document because of its significance in understanding the health of racial and ethnic minority groups in American society. (2001, U.S. Department of Health and Human Services. Mental Health: Culture, Race, and Ethnicity; A Supplement to Mental Health: A Report of the Surgeon General, p. 9.)

SPECIAL POPULATION: Targeted group in a community or area with needs that may require specific attention. Special population may include children, adolescents, older adults, elderly persons, members of ethnic and cultural groups, migrant workers, persons who are severely mentally ill, persons with disabilities, and homeless persons. Other special populations may be unique to the area being served. (2003, U.S. Department of Health and Human Services, Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations, p. 56.)

STANDARDS: The generally accepted principles for the best/most appropriate way to provide clinical care for persons with mental illness; the criteria or set of rules that describe the expected levels of clinical and system behavior as well as course of action based on research and experience. (1997, Cultural Competence Standards, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, p. 59.)

STAKEHOLDERS: Those who have primary interest in the success of programs.

VALUES: A principle, standard, or quality considered worthwhile or desirable.

